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AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION	(X3 · DATE	Q. 0938-0 SURVEY
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	A recertification	survey was conducted from			20	9
	Amil 424 4697 1121	through February 8, 2008. The ted using the fundamental survey			2003	_ 7
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ı		CHERT DODINATION OF FOR TAKE			3 2	莫里斯
	i willi valluus (i ssi	DIITIAS Ibo fiddinan af the			ဟိ	の名と
-	With one clien on	ed on observations, interviews taff in the home and three day	1		ס	ZES.
1	Problems Ba Ne	# 89 & review of client reserve			-	
ĺ	ACCUSATION OF LEAST AND LE	COIDS and incident consule			ćū	₹ 6>
W 120	····vesugation (ari	OTS Ward bled reviewed	.		2	
V 120	OUTSIDE SC UR	RVICES PROVIDED WITH	W 120	ol .	,	
	OO FOIDE SC DR	CES		The OMRP will coordinate with		-
	The facility must a meet the need a m	assure that outside services if each client,		ensure that the BSP is implement that data is collected, and reviews as described by the plan.		
1	review, the far ility	Is not met as evidenced by: ation, interview and record falled to ensure that outside needs of one of three clients in t#2).				3/25/0
-	The finding in Jud	es ;			,	 -
	On February (, 20	08 at approximately 10:07 AM		1	·	
					ĺ	
1	TOOL WITHOUT SELL RELIEF	JIDQ CIRSS IDDT With his 4.4				
Š	pecialist (AT 3) at	VIEW With the Active Treatment	•		ļ	
, .	ALCOHOL MINERAL SIM A	NID THE A I S Matroplay III I II				
	ווושו בשיש כייי	TI DOCI IMAMI (Niant Box)			į	
		or of spitting on the floor on the ior Consequence (ABC) forms			ļ	
, -	AAAAAAA MIS LUCIIII	[[BD][2][A] [[MAR 4][]				
, ,	HALE MESTIC SOLL	MUNICATION With the group				-
MATORY D	RECTOR'S OR I REME	DER/SUPELIED DESSEDENCE TARREST	ATT (B#			
austa	معدد المراجع المسا	222n	\sim	TITLE		(A) DATE
-ficie-Adv			B	vector of Bisability Sen	. •_	1 -1-
afoguards by the data days as the	s provide sufficii nt pro s of survey who her o	an eaterisk (*) denotes a deficiency which objection to the patients, (See Instructions, ringt a plant of confection is provided. For ots are made available to the facility. If d	i ine insonio	on may be excused from correcting a	Marana i le deren	ined that

If continuation sheet Page 1 of 20

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2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES PF::INTED: 02/15/2008 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIE: AND PLAN OF CORRECTION OI<u>/IB NO, 0938-0391</u> (X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER; (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING B. WING 08G010 NAME OF PROVIDER OR SUF PLIER 02/08/2008 STREET ADDRESS, CITY, STATE, ZIP CODE CARECO (11 6417 KANSAS AVE, NE WASHINGTON, DC 20001 SUMMU TY STATEMENT OF DEFICIENCIES (EACH DEF DIGNOY MUST BE PRECEDED BY FULL (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE REGULATOR Y DR LSC DENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPLIATE TAB DEFICIENCY W 120 Continued From page 1 W 120 home about (se decision discontinue collecting data on this techavior. Interview with the Qualified Mental Retardation Professional QMRP) on February 5, 2008 at approximatel: 3:15 PM revealed that the day program was required to documenting each time Client #2 spit as it was a part of his Behavior Support Plan (BSP). Review of Client #2's day program BSF diated August 26, 2007 on February 5, 2008 lister "Spitting on the Floor" as one of his challenging b shaviors. Further report raview revealed that Client #2's BSP for the facility listed "Spitting on tile floor" as a target behaviors and should be do unrented as it occurs. Review of Client #2's log book kept by the AM 1:1 staff failed to evidence of documentation when the spitting behan lo. occurred on February 6, 2008 at the day program. no ease nolisation gnique best in ad bluoda ti February 5, 2)08 at 5:13 PM Client #2 was administered hydroxyzine 25 mg. According to the medical n cord, this medication was prescribed to decrease the client's spitting behavior. W 124 483.420(a)(2) PROTECTION OF CLIENTS W 124 RIGHTS The facility m is: ensure the rights of all clients. Therefore the facility must inform each client, parent (if the slient is a minor), or legal guardian, of the client's medical condition, developmental and behaviol al status, attendant risks of treatment, an I of the right to refuse treatment.

FORM CM\$-2587(02-99) Previous is emione Obsoleta

This STAND/ RD is not met as evidenced by:

EVENI ID: YLYGIT

Feolity ID: 00G010

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2007

CENTE	TMENT OF HE	TH'AND HUMAN SERVICES			PR NTED	: 02/15/200 I APPROVE
STATEMEN	RS FOR MEDIC A	RE & MEDICAID SERVICES			ONB NO	. 0938-039
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPLE CONSTRUCTION LDING	(X3) DATE S	URVEY
		09G010	B. WO	lG		
NAME OF F	ROMDER OR SUPF LE		<u> </u>		02/0	8/2008
CARECO	01			STREET ADDRESS, CITY, STATE, ZIP CO 8417 KANSAR AVE, NE WASHINGTON, DC 20001)DE	
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W 124	L A A LIGHT WARREN LE LE	page 2	W 1	24		
	Based on observative the far lift each cilent or he of the client's read behaviors streatment, and the	ration, interview and record y falled to ensure the right of eir legal guardian to be informed dical condition, developmental catus, attendant risks of e right to refuse treatment for s residing in the facility. (Client	VV 1	24		
	The findings is of	ide:				
	rebruary 6, 20 bit revealed that it list anxiety/deprets sion Mental Retarchation February 5, 20 bit if the dan involve treatment. Retark the Assessment on 15 bit decisions on 1 a bit planning, treatment on 15 bit planning, treatment on 15 bit planning, treatmedical matters, reduced that he decisions on 1 a bit planning, treatmedical matters, and continued the health beneficially authorized of the health beneficial of the health beneficially authorized associated with the medications and conditionally, the fix heat substitute 1 continued in the health beneficial on the health beneficial or	at approximately 5:33 PM at approximately 5:33 PM at #1 was administered Paxil il 25 mg each morning for a. Interview with the Qualified an Professional (QMRP) on at 3:19 PM revealed that Glient d sisters that signs consent for w of Client #1's Psychological ebruary 7, 2008 at 1 PM revealed that the client did capsolity to make independent ehalf regarding his habilitation ant placement, financial, and There was no documented facility informed Client #1 or a representative, as appropriate, fits and risks of treatment e use of his psychotropic orresponding BSP. cility failed to provide evidence nsent had been obtained from id individual or entity.		1. The QMRP will ensure that the decision-maker is informed in writeenefits and risks of recommended (including the BSP if it provides to measures), and will obtain written treatments.	ting of the health I treatmer ts or restrictive	3/25/b8
	:006 at 5:13 F M, C Nonezepam ↑ mg.	dication pass on February 5, Client #2 was administered , Carbamazepine 200 mg, ad Hydroxyzine 25 mg by		2. See response to #1 above.		365/b8

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I ALLEMEN		170	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			CIMB N	M APPROV 0. 0938-03
ND PLAN	OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION ULDING	(23) DATE	
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AME OF	ROVIDER OR SU	PLIER				02/	08/2008
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(%4) (D	SUMN	R C STA	TEMENT OF DEFICIENCIES	·——	WASHINGTON, DC 20001		
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W 124	Continued F	om pag	ge 3 .	10/			<u> </u>
	mouth. Intel Nurse (LPN) 5:40 PM reve	view wi on the a ed th	th the Licensed Practical same day at approximately at the medication was	W -	124	,	
1	the client's c : 7, 2008 at a;	r maiad ment p broxim:	laptive behaviors. Review of hysicians orders on February ately 9:54 AM revealed than				
	a Behavior & . 5, 2007, to a i	kibort i dress i	dications was incorporated in Plan (BSP) dated December behaviors associated with (hitting, spitting at, and				
	inappropriate complete task	iers), si times, i s), self	Iting on the floor (at usually when asked to				
	smearing fer a	s, and	asmirbation (grabbing genital, clothes stripping.				
Į,	M revealed if	SMRP) Tat Clie	alified Mental Retardation on February 5, 2008 at 3:20 rrt #2 has an involved				
F	ebruary 8, # 0	rayene) (18 et a	sent for treatment. Review ogical Assessment on pproximately 9:04 AM it did not evidence the				
b	ehalf regard n Caiment bis 20	ke inde Ig his h Ement	pendent decisions on his abilitation planning,				
th (a	ratters. The re lat the facility i gally-authorize	i was n i∤ifomo ed reor	o documented evidence ed Client #2 or a				
a:	ssociated with	the us	e of his psychotropic				
th	at substitut. d	TBC//ity Consier	falled to provide evidence it had been obtained from dividual or entity.				
I _	Internal and the		ening medication nurse on	J		,	

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DEPAR	RTMENT OF HE	LTH A	ND HUMAN SERVICES				PR NTE	D: 02/15/2008
CENTE	RS FOR MEDIC	ARE&	MEDICAID SERVICES				FOR	MAPPROVED
STATEMEN	OF DEFICIENCIES. OF CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) M		TIPLE CONSTRUCTION	(XI) DATE	0, 0938-0391 SURVEY LETED
ł	•		09 G 010	B. W(2	NO		1]
NAME OF	PROMDER OR SUPI	JER	,	<u> </u>	T		02/	08/2008
CAREC	0 01				1	Treet address, city, state. ZIP code 6417 Kansas Ave, ne Washington, DC 20001		
(X4) ID PREFIX TAG		ENCYMU	MENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID FREF TAG	·IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	II IN ESS	(X5) COMPLETION DATE
W 125	150 mg every in with the Qualities Professional (2) PM revealed in old and did not family members. Review of Client on February 6.2 revealed that it is capacity to make treatment, hall little and financial reduced that he legally-authorities of the health being allocations and Additionally, it is that substitute it is a legally recognited with a legally recognited with a legally recognited and the facility must be a legally recognited and the facility must be a legally recognited with a legally recognited and the facility in the facilit	norning ad Ment MRP) of Ment MRP) of Ment MRP) of the MRP of the M	for depression. Interview al Retardetion on February 5, 2008 at 3:22 t #3 was eighty-three years legal guardian and/or a consent for treatment. sychological Assessment approximately 2:37 PM did not evidence the ons on his behalf about on-going medical care. There was no documented y informed Cliant #1 or a sentative, as appropriate, and risks of treatment of his psychotropic ponding BSP. Falled to provide evidence had been obtained from yidual or entity. TION OF CLIENTS the rights of all olients ust allow and encourage clae their rights as clients zens of the United States, complaints, and the right met as evidenced by: record review, the facility riduals who lacked the ed decisions had identifying a surrogate testion and treatment in the	W 12		4	l with dical informed courdinate	3/25/08
	(02-59) Previous V. raio		_			TL. (F. A.A.A.		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/15/2008 CENTERS FOR MED CARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION CMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (XX) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (XJ) DATE SURVEY A. BUILDING B. WING 09G010 NAME OF PROVIDER OR SUI PLIER 02/08/2008 STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 01 6417 KANSAS AVE. NE WASHINGTON, DC 20001 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEF CIENCY MILET BE PRECEDED BY FULL REGULATO IY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX ΙD PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULT BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETION TAG DATE DEFICIENCY W 125 Confinued From page 5 W 125 The finding it cludes: The facility it lied to ensure Client #1, #2, and #3's rights were p blected by making certain each client had a logally sanctioned representative to assist them vitti making decisions regarding their treatment. [5 en W124] W 159 483,430(a) CUALIFIED MENTAL W 159 RETARDATI ON PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mer tal retardation professional. This STAND, RD is not met as evidenced by: Based on ob. ervations, interviews with the Qualified Me. tal Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen. The findings include: 1. Cross refer to W441. The QMRP falled to 1. The QMRP will ensure that the Residential ensure that haid fire evacuation drills quarterly on Director (RD) will hold and document fire all shifts. evacuation drills quarterly under varied co iditons on all shifts. 2. Cross refer to W249. The QMRP falled to staffs implemented programs as outlined in the 2. The QMRP will ensure that staff from both the residence and the day setting are trained to Individual Program Plans (IPPs). implement each person's IPPs. 3. Cross refer to W193. The QMRP failed to staff demons rated competency in the 3. The QMRP will ensure that staff are traited to implementati n of Client #5's Behavior Support effectively implement client #5's BSP_ Plan (BSP). 4. The QMRP will implement training for all staff

FORM CM5-2857(02-99) Previous 'eminus Obsolete

4. Cross refer to W159. The QMRP falled to

Event ID: YLYG11

effectively, efficiently, and competently. Facility ID: 08G010

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as needed to enable them to perform their cuties

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TATEMEN	T OF DEFICIENCIES OF CORRECTION	RE & MEDICAID SERVICES (X1) PROVIDERSUPPLIENCUA	(X2) MU1 T		NB NC	1 APPRO 0. 0938-0
OND FLAR	DF CORRECTION	IDENTIFICATION NUMBER:	A BUILDIN	V-1	3) DATE S OMPL	ETED ETED
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W 159	Continued From		W 159			1
	ensure that or of	employee was provided with	44 105			
	Continuing trai in	ig that enabled the employee to				1
	and competer ty	ar duties effectively, efficiently,				
ļ	5. Cross refer to	W436. The QMRP failed to		<u>-</u>		
	ensure that Clar	13#2 Was Drovided with necessary	}	5. The OMRP will		
ļ	adabtive equit, in	∌fit (Shower chair)		The QMRP will consure that the client in accessary adaptive equipment.	115	1.
j	483,430(e)(1) 37	AFF TRAINING PROGRAM	W 169			3/25/
	The facility must	provide each amployee with	-			
ŀ	mina and con, br	IING training that enables the	1			ľ
Ī	efficiently, and ed	form his or her duties affectively,	,			
	review, the facility employee was prothat enabled the adulties effective by. The finding including allowing the finding including allowing the finding including the facility allowing the finding the finding telephone was cheep the finding the fi	and to ensure that Client #3's soft placed on his hands in the current physician's orders as 108 at approximately 3:37 PM, arved sitting in a wheelchair hands tightly against his body sylsion. At 5:49 PM direct care it to place hand splints on the 10th Residential Direction (RD) tand splints helps with keeping dether. Further into its place with		1. The QMRP will ensure that the RD and s trained on the physician's orders on the use splints, and ensure that staff implement the cas written.	aff are of the orders	3.bs/
c rc h tr	ident. Intervie v w svealed that the h ls hands tight v to	ito place hand splints on the lith Residential Direction (RD) trans splints helps with keeping lighter. Further interview with leat the client should wear the				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/15/2008 CENTERS FOR MED CARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION Q <u>VIB NO. 09</u>38-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (XI) DATE SURVEY COMPLETED A. BUILDING B. WING. 09G010 NAME OF PROVIDER OR SUIT PLIER 02/08/2008 STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 01 6417 KANSAS AVE, NE WASHINGTON, DC 20001 SUMM. RY STATEMENT OF DEFICIÊNCIES (EACH DEF CIENCY MUST BE PRECEDED BY FULL REGULATOLY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPULATE (X5) COMPLETION CATE PREFIX TAG TAG DEFICIENCY W 189 Continued Fi om page 7 W 189 hand splints laily and should be removed by dinner time. Review of the current physician's dated Januar / 2008 on February 6, 2008 at approximatel '2:37 PM revealed the client has a diagnosis of Gerebral Palsy with Spastic Quadriplegia. Multiple Flexion Contractures, and Arthritis. Fur heir review of the physician's orders revealed an crder for soft hand splints to prevent further contractures. "The soft hand splints should be place on the client's hands in the morning after the morning care from 9:00 AM to 1:00 PM and emove from 1:00 PM to 3:00 PM. Put splints back on from 4:00 PM to 8:00 PM then interview-with Qualified Mental Retardation Professional : QMRP) on February 6, 2005 at 3:00 PM revealed : hat Client #3 was admitted to the facility from a lother provider on January 31, 2008. When isked if all staff had been trained on the use of Cli. nt #3's soft hand splints, the QMRP stated all staf are scheduled to be trained on February 13, 1008. Note: It should be noted that on February 6, 2008 at from 11:03 AM to 12:00 PM Client #3 was not observed to we sair his soft hand splints in accordance with the physician's orders. 2. On February 5, 2008 at 5:13 PM Client #2 was 2. The QMRP will ensure that the RD has a process administered lenna-S tab for constipation. The for checking data collection and reporting errors so client was also prescribed Docusate Sodium 100 that retraining can be implemented as needed. The mg two caps: le daily at bedtlime for constipation. Director of Disability Services will meet with the According to 1 ie bowel tracking chart reviewed on QMRP, RD and nursing staff to ensure that it February 8, 21 03 at 12:46 PM, Client #2 did not timely and complete communication loop is have a bowel novement for three (3) days (2/1, established and maintained so that nursing s aff can 2/2, and 2/3/0 l). Review of the Standing properly react to clients' medical needs. Physician's O: ters S for "Constipation" revealed

FORM CMS-2567(02-99) Previous \" as one Desolete

the following r posedures:

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Facility ID: 09G010

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ND PLAN	T OF DEFICIENCIES	IRE & MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·	ONB	RM APPRO'NO. 0938-0	
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	1 150	TE SURVEY MPLETED	
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IAME OF P	ROVIDER OR SUPF JI	ĘŖ	57	REET ADDRESS, CITY, STATE, ZIP CODE	02/08/2008	
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W 189	Continued From	page 8	W 189			
	give prune juli s 48 hours or	gnesia				
	Nurse (LPN) cornurse and glv. p standing phys of the LPN rever let that the client did three days. In an Director rever ed movement will him	a facility's Licensed Practical infirmed that staff should notify the trune juice in accordance with the an orders. Further interview with an orders. Further interview with a that she was not made aware I not have a bowel movement to view with the Residential I that Client #2 had a bowel at those days, but staff forgot to	1			
	record it.	•	1			
	2. Cross refer to ensure that stirff implementing on individual Program	W249. The facility failed to had received effective training in organis as outlined in the m Plans (IPPs). AFF TRAINING PROGRAM	w 193	2. See response to W249. The QMRP will: nsur that all staff are trained on implementation of each client's ISP as soon as the Interdisciplinary Fean has formulated it.	e h	
№ 193	2. Cross refer to ensure that striff implementing on Individual Program 483.430(e)(3) ST Staff must be ablitechniques ne assto manage the instantial company of the instantial	had received effective training in organis as outlined in the im Plans (IPPs). TAFF TRAINING PROGRAM to demonstrate the skills and seary to administer interventions appropriate behavior of clients.	W 193	that all staff are trained on implementation of each client's ISP as soon as the Interdisciplinary Feart has formulated it.	3/25/6	
W 193	2. Cross refer to ensure that striff implementing on Individual Program 483.430(e)(3) ST Staff must be ablitechniques ne test to manage the instance on the strip Based on obs are review the facility	had received effective training in params as outlined in the im Plans (IPPs). TAFF TRAINING PROGRAM to de to demonstrate the skills and sarry to administer interventions appropriate behavior of clients. Is not met as evidenced by: ations, interviews, and record staff failed to demonstrate templementation of Client #5's	W 193	that all staff are trained on implementation of each client's ISP as soon as the Interdisciplinary Fearth has formulated it. The QMRP will ensure that all staff adhere to the standards governing the 1:1 staffing duties. Staff who are unwilling or unable to adhere to the	3/25/	

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Facility ID: 09G010

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			09 G010	B. WII	√G	057	77/77 00	
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	, ,				WASHINGTON, DC 20001			ł
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W 193	Continued F	שבת חוב	na 0					\dashv
71 133	The facility for staff remains	ileid to d in clo xb dutio	ensure that Client #5's 1:1 se proximity in accordance as and responsibilities as	W	193			
	to stand on the king of the client reminutes before the trail or remains.	e front chen p nained corn 1:1 a vithin	8 at 4:33 PM Client #5 was to kitchen area to go outside porch. Client #5's 1:1 staff reparing the dinner meal, outside on the porch for two ling back into the facility. At staff leave the kitchen area to eyesight of Client #5 as wor management plan.					
ļ	Professional (approximate) approximate) received 1:1 physically aggelopement at interview with primary duties remain within Client #5 at 1 records on Fethat all staff: If 1:1 job duties evidence the 483.440(c)(E) (The individual opportunities of self-manage in This STAND, We Based on objective individual opportunities of self-manage in the self-manage i	C:MRF / 10:00 traffing // 10:0	ualified Mental Retardation a) on February 8, 2008 at AM revealed Client #5 24 hours a day to manage a behaviors to prevent ang self and others. Further MRP revealed that one of the 1:1 staff person was to the and/or arms length of Review of the staff training 8, 2008 at 9:12 AM revealed and received training on their sponsibilities. There was no g was auccessful. INVIDUAL PROGRAM PLAN Im plan must include at choice and not met as evidenced by: a and interview, the facility Client #2 was provided the	W 2	The QMRP will ensure that staff are re engaging client #2 in self management opportunities for self directed activities	and offering	3/25/08	

FORM CMS-2567(02-99) Previous Versions Obsolute

Evera ID: YLYG11 Facility ID: 096010

If continuation sheet Page 10 of 20

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DEPAR CENTE	RTMENT OF HE	TLI.	I AND HUMAN SERVICES			•	FOR	D: 02/15/2008 M APPROVED	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION		OX1) PROVIDENCULA IDENTIFICATION NUMBER:	(XZ) M A. BU		IPLE CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY LETED	
			09G010	09G010 B. WING				1 	
NAME OF	PROVIDER OR SUPI O 01	N STEEL		· ·····	STREET ADDRESS, CITY, STATE, ZIP COD 6417 KANSAS AVE, NE WASHINGTON, DC 20001		02/	08/2008	
(X4) ID PREFIX TAG	(EACH DEPK	IEI IC	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REPERENCED TO THE APPR	II D S F	(X5) COMPLETION DATE	
	opportunities: self-managem The finding inc Evening obser 2008 at appro- #2's 1:1 staff of Client #2 was sitting in the client #2 required with normally assistraightening of Client #2 required with this task of the 1:1 staff of with organizing evidence that opportunity for his capabilities 483,440(d)(1) As soon as the formulated a client multiple and frequency interventions are and frequency interventions are also and frequency interventions and frequency interventions are also and	or many series of the control of the	aking choices as part of their six conducted on February 5, ely 4:16 PM revealed Client sing his close in his bedroom. Ved to be sleeping while the front of the bed. 1 staff revealed that Client #2 in folding laundry and closet. The 1:1 stated that and over hand assistance his blindness. At no time did encourage Client #2 to assist encourage e	W 2		DEFICIENCY	esid moe	3/25/08	
504 50 45 55	sample. (Clier t	or thro #63)	ee clients included in the						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

FRINTED: 02/15/2006 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCE S AND PLAN OF CORRECTION CMB NO. 0<u>938-0391</u> (X1) PROVIDER/BUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A BUILDING COMPLETED B. WING 09G010 NAME OF PROVIDER OR SU PLIER 02/08/2008 STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 01 8417 KANSAB AVE, NE WASHINGTON, DC 20001 SUMM RYSTATEMENT OF DEPICIENCIES (X4) ID PROVIDER'S FLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULT BE
(ROSS-REFERENCED TO THE APPROPRIATE PRÉFIX (EACH DE ICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION REGULATO LY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY W 249 Continued From page 11 W 249 The finding includes: On February 5, 2008 at approximately 6:22 PM Client #1 wa served sweet potatoes, roasted turkey breast collard greens, and beverage pureed during his dinner meal. The client was observed to receive total assistance from his 1:1 staff person. Interview with the 1:1 staff revealed that the clien is totally dependent with feeding and his ADL :kills. On February 8, 2008 at 12:11 PM the client was observed during lunch at his day program. The client was se veid mixed vegetable, baked fish, and wheat bread pursed. The assigned 1:1 staff was observed to feed Client #1 using hand over hand assistal co and encouraging him to raise the spoonful of fc cal to his mouth during the entire meal. Interview with the 1:1 staff at the day program reve sled that she was trained to feed Client #5 using hand over hand assistance. The 1:1 staff furth ir revealed that Client #5 had an objective to raise his spoon with food to his mouth with hand over hand assistance. Review of Cli :nt; #1's Individual Program Plan (IPP) dated J muary 24, 2008 on Fabruary 7, 2008 at approximately 3:11 PM revealed a program that itered "with hand over hand assistance, the client will raise his spoon filled with food to his mouth three times with 100% accuracy for fill consecutive months." There was no evidence that the Client #1 was afforded the opportunity fo self-management and encourage to participate in his programs during the dinner meal on Febr. ery 5, 2008. 483.440(f)(3)(i) PROGRAM MONITORING & W 263 W 263 CHANGE

FORM CMS-2587(02-99) Previous \ arsions Obsolete

Event ID: YLYG11

Facility ID: 09G010

If continuation sheet Page 12 of 20

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DEPAR	RTMENT OF HE	ALTH AND HU	MAN SERVICES				PEINTE	D: 02/15/2008	
_ÇĒNTE	RS FOR MEDI	XRE & MEDIC	AID CEDVICES				FOR	M APPROVED	
ISIAIEMEN	IT OF DEFICIENCIA	CAL PROVE	NID SERVICES	_,_			OMB N	Q. 0938-0391	
AND PLAN	OF CORRECTION	IDENTIF	DER/SUPPLIER/CLIA CATION NUMBER:	(X2) I A. BU		TIPLE CONSTRUCTION	CCS DATE		
			09G010	B. WI	NG				
NAME OF	PROVIDER OR SUF	LIR			Τ		02/08/2008		
CAREC	O 01				ı	TREET ADDRESS. CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE WASHINGTON, DC 20001		,	
(X4) ID	SUMMA	TY STATEMENT OF	DEFICIENCIES	100	_				
PREFIX TAG		JENCY MUST BE PR COR LSC IDENTIFYI	BOODEN IN BUILD	PREF	X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	li n ac	(XS) COMPLETION DATE	
W 263	Continued Fr.	m page 12	-	W:	263				
ļ	are conducter	only with the wr	hat these programs itten informed if the client is a						
	review, the far committee (Hi ensure that re- with written co:	RD is not met an invation, interview invation, interview interview interview interview programs for three sample. (Client:	W, and record constituted cons		•	·	·		
1	The findings in		·	•					
	consent had be consen	te fallet to ensure on obtained for it out Plan (BSP) the critical Mental it likely on Februaria PM revealed informed consecuted noted, accounts alsters is "in a evidence that the conference of psychotrometrical processes of psychotrometrical mental transport of the conference of the conference of psychotrometrical mental transport of the conference of psychotrometrical processes of psychotrometrical mental psychot	the use of at incorporated pic medications. Retardation any 8, 2008 at it that Client #1 did ent signed by a rding to the volved in his life, hey had been spic medications.			1. See response to W124. The Human Ri Committee has a procedure to review the restrictive measures, including the use of psychotropic medicines; the QMRP will e such restrictive treatments for client #1 and before the HRC for approval.	us of all	3/25/08	
ti Ir	grise committing to consent had been some supplied to the use of presonterview with 1). Professional (1)	ence W124] The challed to ensure the failed to ensure the failed for the failed for the failed psychotropusified Mental RVIRP) on Februa 32 PM revealed	a that informed he use of at incorporated hic medications.			2. See response to #1 above.		3/25/08	
M CMS-2567	(02.01) Previous V. IS	lons O hsojqta	Event ID: YLYG11	F	Fact	lty ID: 09G010 If profinues	<u> </u>		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FRINTED: 02/15/2008 FORM APPROVED

STATEMEN	T OF DEFICIENCE	8	(X1) PROVIDER/SUPPLIER/CLIA			CMB N	10.0938-03
AND PLAN	OF CORRECTION		IDENTIFICATION NUMBER:	(X2) M(ULTIPLE CONSTRUCTION DING	(X3) DATI	SURVEY PLETED
			096010	B. WIN	3	-	
NAME OF	PROVIDER OR SU	PLIER				02	/08/2008
CAREC	0 01				STREET ADDRESS, CITY, STATE ZIP: 6417 KANSAS AVE, NE WASHINGTON, DC 20001	DODE	
(X4) ID PREFIX	SUMM.	RTBTA	TEMENT OF DEFICIENCIES	10			
DAT	REGULATO	Y OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF O (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULE BE LE APPROPRIATE	COMPLETIC: DATE
W 263		orn pag	g a 13	W 26	13		-
	QMRP, the country was	ient's t ient's t	ormed consent signed by a noted, according to the nother is " involved" in his life, idence that they had been of psychotropic medications.	7 4 44.			
	3. [Cross Rerights commiconsent had Behavior Supthe use of principles.]	erence tee fail seen of port Pt scribed	e W124] The facility's human ed to ensure that informed ptained for the use of an (BSP) that incorporated		3. See response to #1 above.	·	3/25/08
	Professional approximate; did not have guardian. The	QMRP 1:34 F vilten i vre was	ed Mental Retardations) on February 8, 2008 at "M revealed that Clients #3 informed consent signed by a ino evidence that they had use of psychotropic				
N 322 A	483,460(a)(3)		CIAN SERVICES	W 322			
	The facility m i general medir :	s∷prov al care	ride or obtain preventive and				
r	eview, the faci	r/apor lity faile lior tw	not met as evidenced by: i, interview and record ed to ensure general and o of three clients included in 2 and #3)				1
Т	he findings i \cdot	dude:					
A C In	M revealed i no oliar" as par' o liar" as par' o liar" as par' o liarview with the urse (LPN) and	Jary /, 9 Client of his a 10 facili	I's current physician's 2008 at approximately 9:54 Was prescribed a "Cervical daptive equipment. Ity's Licensed Piratical ified Mental Retardation		1. The QMRP will ensure that the recommendations and length of tin should use the cervical collar is cle 1SP. The QMRP will ensure that it training on how to implement and cuse of the cervical collar, and that it have a protocol for monitoring the of the neck support.	ne the client arly stated in his he staff it ceive documen the	

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DEPAR	TMENT OF HE 4	LTH AND HUMAN SERVICES		•	PRINTEL	D: 02/15/2008	
CENTE	RS FOR MEDIL	ARE & MEDICAID SERVICES				MAPPROVED 0. 0938-0391	
Statemen and Plan (T of Deficiencie Of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE (COMPL	SURVEY	
		49G 010	B. WIND _		02/08/2008		
NAME OF F	ROVIDER OR SUPIL	JER	STR	LEET ADDRESS, CITY, STATE, ZIF GODE		OBIZUUS	
CARECO	0 01		F-	417 Kansas ave, ne Vashington, dc 20001			
(X4) ID	SUMMA ()	STATEMENT OF DEFICIENCIES	I ID	PROVIDER'S PLAN OF CORRECT	TION —	13.5	
PREFIX	(EACH DEM 3)	ENCY MUST BE PRECEDED BY FULL (:R LSC IDENTIFYING INFORMATION)	PREFIX YAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	MILLION ARE	(X5) COMPLETION DATE	
W 322	Continued Fr. n	n page 14	W 322			 	
	Professional , 2	MRP) on February 8, 2008 at	VV 322				
. 1	approximately 1	D:00 AM revealed that the client]				
	should wear the	cervical collar during bedtime					
ŀ	only Review of	Client #2's Individual Support	1		,		
	Plan (ISP) an ei	rided December 20, 2007 under				1 (
	me section et (iii	iled "My assistive Devices", e cervical coller was to be worn at					
	bedtime and un	e cervicer coller was to be wom at ten in the facility. Further				1 [
	interview with th	REP revealed that the client	1			}	
,	refused to we in	the collar inside the facility. He				.]	
ĺ	will take it off. T	he QMRP stated that it was her					
-	mistake of no a	dressing this issue to the	1				
	interdisciplina y	Team (IDT) this past ISP and				1	
.	collar while in th	coument his refusals to wear the facility. Review of the Physical	1				
	Therapy asse is	ment dated October 12, 2007	1 .				
	failed to reflect t	ne purpose, recommendations	[]				
	and length of in	10 for the use of the collar. The	1			1	
	assessment falle	ed to provide instructions for	[[1	
1	direct care staff	to ensure appropriate	! !			1	
- 1	implementation	or this prescribed support	1 1]	
- 1	had been doned	alled to revealed that a protocol					
[ned been dev ilc	ped by the nursing staff and that in was available to support the]			1	
	nursing staff r in	nitoring the implementation of this	1			j	
.	neck support or	Client #2.	[]	•			
			1			1 . [
	2. The facility fa	iled to ensure that Client #3's soft]	2. See response to W189 #1.] [
	nand spiints y, eri	a wom in accordance with the		2. Dec response to W165 #1.		13/1/2	
,	Content buyer an	n's orders as evidence below:	!			725/08	
	Ön Februarv : . ⊅	2008 at approximately 3:37 PM,					
] [Client #3 was 5b	served sitting in a whaelchair	<u> </u>			1	
1 1	Milli his siths an	d hands tightly appinst his body	1			1	
- 1	wniie waltchini te	Sevision. At 5:49 PM direct care		•] [
	Statt was obs: [v:	ed to bisce hand splints on the		<u>.</u>			
	alent intervew	with Residential Direction (RD)		·] [
i	tie hende tier iv:	hand splints helps with keeping together. Further interview with				1	
						1	
RM CMS-2567	7(02-99) Previous \ arsi	one Obsolete Rvani ID: YLYG1:	Facil	ly ID: 09G010 If contin	uation sheet	Page 15 of 20	

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PRINTED: 02/15/2008 DEPARTMENT OF HILALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIE; AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XI) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 096010 02/08/2008 NAME OF PROVIDER OR SUI FLIER STREET ADDRESS, CITY, STATE, ZIF CODE 6417 KANSAS AVE, NE CARECO 01 Washington, DG 20001 (X4) ID PREFIX SUMM: RY STATEMENT OF DEFICIENCIES PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE (EACH DET CHENCY MUST BE PRECEDED BY FULL REGULATOLY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION DATE PREFIX TAG DEFICIENCY W 322 Continued From page 15 W 322 the RD revea sal that the client should wear the hand splints laily and should be removed by dinner time, Review of the current physician's dated Januar / 2008 on February 6, 2008 at approximatel / 2:37 PM revenied the client has a diagnosis of Derebral Palsy with Spastic Quadriplegia, Nultiple Flexion Contractures, and Arthritis. Fur her review of the physician's orders revealed an arder for soft hand splints to prevent further contractures. "The soft hand splints should be place on the client's hands in the morning after the morning care from 9:00 AM to 1:00 PM and e-move from 1:00 PM to 3:00 PM. Put splints be ak on from 4:00 PM to 8:00 PM then off." Interview with Cualified Mental Retardation Professional QMRP) on February 6, 2005 at 3:00 PM revealed hait Client #3 was admitted to the facility from a nother provider on January 31, 2008. When asked if all staff had been trained on the use of Cli ant #3's soft hand splints by the Nurse, the Qi IFIP stated all staff are scheduled to be trained on February 13, 2008. W 331 483,460(e) N JRISING SERVICES W 331 The facility must provide clients with nursing See response to W189. services in ar cordance with their needs. 3/25/08 This STAND, RD is not met as evidenced by: Based on stall Interview and record review the facility failed to ensure nursing services in accordance v. ith the needs of two of two clients in the sample. (13/ksnt #1 and Cilent #2) The finding in dudes:

FORM CMS-2567(02-99) Provious * emiorie Obsalete

Cross refer to W322.2. The facility's nursing staff

Event ID: YLYG11

Plainty ID: 09G010

if continuation sheet Page 16 of 20

02/15/2008 06:47 AX 2024429430

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DEPAR	TMENT OF HE	LTF	AND HUMAN SERVICES .	•			PRINTED:	02/15/2008
			& MEDICAID SERVICES				MRQ= OME NO	APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLĘ CONSTRUCTION IG	(X3) DATE SI	URVEY
			09G 010	B. WII	NG_			
NAME OF	PROVIDER OR SUPF	JER.		<u>-</u>	e TE	REET ADDRESS, CITY, BTATE, ZIF CODE	02/0	8/2008
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1EE W	Continued Fro	אלן מ'	ge 16	w:	121			
W.356	failed to ensur were worn in a physician's on	a tha coorders.	t Client #3's soft hand splints dance with the current PREHENSIVE DENTAL	w:				
	ireatment servineed for rel	ef of	sure comprehensive dental that include dental care pain and infections, and maintenance of dental			The QMRP will coordinate with the me to ensure that clients receive comprehent treatment services.		3/25/08
W 436	483.470(g)(2) The facility mushd teach clies choices about hearing and or and other days	SP'AC st fur its to the u her o ses k	s not met as evidenced by: CE AND EQUIPMENT rish, maintain in good repair, use and to make informed se of dentures, syaglasses, ornmunications aids, braces, lentified by the m as needed by the client.	W	136	The QMRP will ensure that the client has chair as recommended in the PT assessor	as a : hower nent	<i>3/25/08</i>
į	Based on obserview, the fact was provided to (shower chair)	ity fa lity fa lith n	not met as evidenced by: ons, interview and record iled to ensure that Client#2 scessary adaptive equipment					
1	The finding incl	udes	;					
	revealed Clien: assistance will ((ADL). Interview February 6, 200	#2 w rnob w wit Ki at	cted on February 5, 2008 ras blind and required iiity and Adaptive Living Skills h his assigned 1:1 staff on 3:01 PM revealed that Client the some ADL skills with hand					

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				AND HUMAN SERVICES MEDICAID SERVICES				FORM	: 02/15/2008 APPROVED
SY	ATEMEN	T OF DEFICIENCIE OF CORRECTION		(X1) PROVIDENSUPPLIERCLIA IDENTIFICATION NUMBER:	1 .	AULTII (LDING	PLE CONSTRUCTION	CAS DATES	
				09G010	B. Wil	NG_		02/0	8/2008
	AREC	PROVIDER OR SUF D 01	'UER			64	SET ADDRESS, CITY, STATE, ZIP CODE 417 KANSAS AVE, NE /ASHINGTON, DC 20001		
f	(X4) ID PREFIX TAG	LEACH DEF	RENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY PULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	UI.D BE	COMPLETION DATE
		over hand as putting on clo showers. Relapproximately. Therapy (PT) 2007. According and a shower interview with Professional (approximately not have a ship documented (with the show recommende 483,470(i)(1). The facility mivaried condition of the facility mivaried condition of the finding law record verificate evacuation of the finding law record verificate evacuation of the february 6, 24 drills were consisted in the february 6, 25 drills were consisted in the february 6, 24 drills were consisted in the february 6, 25 drills were consisted in	island hess, to 10:30 hess, to 10:30 hess, to 10:30 hess ling to 10:30	ce including touthbrushing, washing/drying hand, and eview on February 7, 2008 at 0 AM revealed a Physical sament dated October 12, the assessment, it was Client #2 utilize a grab bars to assist with showering, ualified Mental Retardation P) on the same day at PM revealed that Client #2 did chair. There was no ce that Client #1 was provided hir to assist with showering as PT assessment. UATION DRILLS id evacuation drills under the facility failed to hold the varied conditions.	W	436	The QMRP will ensure that the RD ho cvaruation drills on all shifts at least quantity varied conditions.		3/25/68

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DEPAR	TMENT OF HE	LTH	AND HUMAN SERVICES				PR NTEI	D: 02/15/2008 MAPPROVED
CENIC	KS FOR MEDIC	AKE	& MEDICAID SERVICES				ON B NO	0.0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	i	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE	
			09 G 01D	B. WII	NG_		02/	N9/2006
NAME OF I	ROYIDER OR SUPI	JER				02	08/2008	
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W 441	the side door had not been shift. There we drills were held 483,480(a)(1) SERVICES Each client m well-balanced	ixit at isad: isad	nd the exit on the upper level at least quarterly on each evidence that evacuation er varied conditions. O AND NUTRITION ceive a nourishing, including modified and	W 4		The QMRP will ensure that staff are traproperly and accurately measure the cli	ent's food	
	Based on obsi- review, the fact diets addresse two clients in the finding Inc. On February & Client #2 was turkey breast, beverage during preparing the portions that with the staff of that Client #2 of the client #2 of the client #2 of the client #3 of the client #4 of the client #5 of the clie	RED is investigation of the said of the sa	not met as evidenced by: on, interview, and record illed to ensure therapeutic nutritional needs of one of mple. (Client #2)			servings so that his diet conforms to the recommended by the Nutritionist.	diet	3/25/08

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CENTE	RS FOR MED	CARE	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 02/15/20 FORM APPROVE		
STATEMENT	T OF DEFICIENCIES OF CORRECTION	3	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	O MB NO	URVEY	
				A. BUILDING		COMPLETED		
NA ME AE D	PO 150 A		09 Q0 10	E. WING_		02/08/2D08		
CARECO	ROMDER OR SUF 01	²LER.		04	ETADDRESS, CITY. STATE, ZIP CODE 17 KANSAS AVE. NE	1 02/1	012008	
(X4) ID	SUMMA	RY STA	TEMENT OF DEFICIENCIES		ASHINGTON, DC 20001			
PRÉFIX TAG	REGULATO	Y OR U	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDEN'S PLAN OF CORRE (BACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OURSE	COMPLETE DATE	
W 460		ını pa	ge 19	W 460			 	
	portions that meet his diet	veres ĭy ne∈	erved to the client in order to eds.	17 405			<u> </u>	
1								
					,			
						-		
CMS-2587(0	2-99) Previous Vi s	ic ne Oha	cieta Event ID: YLYG11		י מפכמים			

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PF:INTED: 02/15/2006 FORM APPROVED

STATEMEN AND PLAN	rt of Deficiencié Of Correction	ì	(X1) PROVIDER/SUPPLE	ER/CLIA MBER:	B. WING		0X3 DATE SURVEY COMPLETED	
NAME OF	ROVIDER OR EUP	4 11 12	09G010	T kere			02/	08/2008
NAME OF A	KOAIDEK OK END	UIĘR				STATE, ZIP CODE		
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(X4) 1D PREFIX TAG	i (Each Defi	HENCY	ATEMENT OF DEFICIENCIE AUGT BE PRECEDED BY SCIDENTIFYING INFORMA	Ort fr t	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	In Po 4C	COMPLETE
1 000	INITIAL COM	MENT	rs		1000			
	5, 2008 through was initiated a process. A reselected from with various discussions administrative investigation and appropriate address and	In Fall sing the state of the s	ad, and served by incinstruction from a die met as evidenced by; on, interview, and rectabled to ensure their nutritional needs of omple. (Resident #2)	survey rey rate was males the reviews co day coords cord stition; rord apeutic one of 22 PM roasted as his aff food 3:16 PM diet otated "	. 042	The QMRP will ensure that staff are tra properly and accurately measure the clic servings so that his diet conforms to the recommended by the Nutritionist.	nt'i food	3/25/68
alth Regula	on Administratic 1							
BORATORY	DIRECTOR'S OR 'S	ROVIDE	R/BUPPUER REPRESENT	ATTVE'S SIGN	IATURE &	Director of Disability Lives	,	(X5) DATE
ATE FORM				01	90s N	2 23	<i></i>	157 /06

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FRINTED: 02/15/2008 FORM APPROVED

AND PLAN OF CORRECTION		13	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM	volja MBER:	A BUILD	ING	(3) DATE COMPI	SURVEY LETED	
			09G010		B' MING				
NAME OF I	PROVIDER OR SU	PUER	,	STREET ADD	ESS, CIT	, STATE, ZIP CODE	02/	08/2008	
CARECO				6417 KANS WASHINGT	M7 KANSAS AVE, NE ASHINGTON, DC 20001				
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1.4.4				ION)	DAT	CROSS-REFERENCED TO THE APPROP	RATE	DATE	
1 042					042				
	repruary 7, a revealed that calorie low fathat Resident low fat, low conditions and evidence	O(18 at Reside t, ow c : Nutriti #2 wa noleste hat the were se	nt physician's orders of approximately 9:54 A appro	M a 1800 diet. evealed alorie lere was					
	DE MRII COUSI	and n ucted.	PING naintenance equipme properly maintained a notion for which it is to	int shall	091	The QMRP will ensure that the doorbell is or replaced.	epaired	3/25/	
	based on ob: : failed to mair ;	ervation ain the 1 a safe	et as evidenced by: to and interview, the interior and exterior (c, clean, orderly, attra	of the				ļ	
7	The finding in :	ludes:	-						
ti 2	viental Ketar: (he environm: (2008 reveale:	ition Pi 11al wa that the	view with the Qualifie rofessional (QMRP) d ik through on Februar a door beli located at observed not functio	luring ry 8,					
1135 3	505.5 FIRE ∷	AFETY	,	1 1	35	•			
U	ach GHMRF : rder to test ti d our (4) times :	: eπect	onduct simulated fire of iveness of the plan at	drills in Lleast		The QMRP will ensure that the RD holds in evacuation drills on all shifts at least quarter under varied conditions.			

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ND PLAN	IT OF DEFICIENCIES OF CORRECTION		(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM	RICLIA ABER:	(X2) MULT A. BUILDIN B. WING		(DOS) (VATE (SURVEY ETED	
		09G010					02/0	02/08/2008	
AME OF P	ROVIDER OR SUPPI	ER				STATE, ZIP CODE			
CARECO				Washin	nsas ave. 1 Gton, DC 2	NE 10001	,		
(X4) ID PREFIX TAG	(EACH DEFIC	ENCY	ITEMENT OF DEFICIENCIES MILIST BE PRECEDED BY I SC IDENTIFYING INFORMA	ECH (ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BIT THE APPROPRIATE	(XS) COMPLE DATE	
1 135	Continued From	וַבּכון ר	ge 2		l 135				
	Based on obser- record verifica: evacuation drii:	nut met as evidenced by: vations, staff interview, and on, the GHMRP failed to hold under varied conditions.							
	February 6, 20)	icility 8 at	s: y's fire drill records or 1:16 PM revealed th: ucted via the front an	at the					
	door exits. In: a Retardation Product of the Cay at 2:10 PM (least five methor) with the QMRF.	rrieve reve d of reve	w with the Qualified Miconal (QMRMP) on the aled that the facility has been something in the saled that there's an e	Mental Le same Lad at rview exit			·		
	upper level of () Further review of the side door () had not been us shift. There was	e fac f the It an ed a i no	(Side Door) and exit collity leading to the bactifier drill record reverse the exit on the uppet least quarterly on exidence that evacual varied conditions.	ack yard. aled that er lavel ach		· .			
1 206	3509.6 PERSC N	INE	L POLICIES		1 206				
	annually there: fi certification that t performed and ti	er, s ei he tet t	or to employment and shall provide a physic saith inventory has be the employee 's heal er to perform the req	ian 'a ian in status					
	Based on inter 46	w a	net as evidenced by: and record review, the sure that all staff had file.	entaut					

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STATEMENT OF DEFICIENCIE (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3; DATE SURVEY COMPLETED A. BUILDING B, WING 09G010 NAME OF PROVIDER OR SUPILIER 02/08/2008 STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE CARECO 01 WASHINGTON, DC 20001 SUMMAI Y STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I.E. CROSS-REFERENCED TO THE APPROPR ATE (EACH DEFI IENCY MUST BE PRECEDED BY FULL REGULATOR OR LSC IDENTIFYING INFORMATION) PREFIX TAG COMPLETE TAG DEFICIENCY) 1206 Continued From page 3 1206 The findings include: Review of "as personnel files conducted on February 8, 2008 at approximately 9:12 PM i. The Human Resources Director will ensu e that revealed the CHMRP failed to provide evidence 3/25/08 Staff #4 has a current health certificate on file. of current current health certificates for one staff. (S #4) 1 227 3510.5(d) ST# FF TRAINING 1227 Each training : regram shall include, but not be limited to, the ollowing: (c) Infection c. nirol for staff and residents; This Statute is not met as evidenced by: Based on rect of raview, the GHMRP failed to have on file to review current training in first Aid and CPR for employees. The findings in slude: On February & 2008, review of personnel records/trainin | records revealed that the following staff: were without current First Ald and CPR, or both. 1. The Human Resources Director will ensure that Staff#4 and #16 have evidence of current Cl-R on 1. Current CPF: - S #4 and S #16 3/25/08 file. . 1392 3520.2(b) PRC FESSION SERVICES: GENERAL 1392 **PROVISIONS** Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habil tation plan, as determined to be necessary by the interdisciplinary team. The Health Regulation Administration

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NAME OF PROMDER OR SUP - USE CARROO 01 SUMMA Y STATEMENT OF DEPOCEMENTS BASEN BAS
WASHINGTON, DC 20001 PREFIX (EACH DEF) SENCY MUST BE PRECISION BY PULL TAGE (EACH DEF) SENCY MUST BE PRECISION BY PULL TAGE (EACH DEF) SENCY MUST BE PRECISION BY PULL TAGE (EACH DEF) SENCY MUST BE PRECISION BY PULL TAGE (EACH DEF) SENCY MUST BE PRECISION BY PULL TAGE (EACH DEF) SENCY MUST BE PRECISION BY PULL TAGE (EACH DEF) SENCY MUST BE PRECISION BY PULL TAGE (EACH DEF) SENCY MUST BE PRECISION BY PULL TAGE OF THE APPROPRIATE OF THE PULL TAGE OF THE APPROPRIATE OF THE PULL TAGE OF THE APPROPRIATE OF
TAGE TAGE TAGE TAGE TAGE TAGE TAGE TAGE
professional: ervices may include, but not be limited to, the sestices provided by individuals trained, qualificensed as required by District of Columbia taw in the following disciplines or areas of services: (b) Dentistry. This Statute is not met as evidenced by: Based on other erview, the G-MRP failed to ensure comprehensive treatment services for the maintenance of dental health for two of three residents in the example. (Client #1 and #2) The findings include: 1. Review of Resident #2's medical records on Fabruary 7, 2 108 at approximately 11:04 AM revealed a dinital consult dated September 19, 2007. The creative was the follow up from the October 3, 20 Gi dental appointment. The dentist findings was neclerate calculus deposits and recommended 1 patient needs scaling "will submit pre-authorize ion to Medicaid for approval" Interview with the Qualified Mental Retardation Professional QMRP) and facility's Licensed Practical Nurve (LPN) on February 8, 2008 at approximately "1:10 PM confirmed that Resident #1 had not be an back to the dentist since of the survey, the fraility was still waiting for approval for dental services (Sosling) and that she was following up 1 th this issue. At the time of the survey, the fraility falled to provide evidence that Resident #1 received timely dental services. There was all on o evidence of the facility's efforts to assist with the obtainment of the
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (XS) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING COMPLETED E. WING 09G010 NAME OF PROMDER OR SUPILIER 02/08/2008 STREET ADDRESS, CITY, STATE, ZIP CODE 6417 KANSAS AVE, NE CARECO 01 WASHINGTON, DC 20001 SUMMA: Y STATEMENT OF DEFICIENCIES (EACH DEFI: IE-YCY MUST BE PRECEDED BY FULL REGULATOR 'CR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD HE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (XS) TAG DATE TAG 1392 Continued Frt. m page 5 1392 On Februal y 5, 2008 at approximately 3:38 PM Resident: 2 was observed to have 2. See response to #1 above. 3/25/08 discoloration around his teeth. Review of Resident #2's medical records on February 7, 2008 at appre dinately 9:54 AM revealed a dental consult dated December 4, 2006. According to the consult, the dentist recommended scaling due heavy moders to calculus deposits, and indicated she"will subm ; cre-authorization to Medicaid for approval." Fu ther record review revealed another denta consult dated November 6, 2007. According to the consult, there was slight mobility with teath #10 and moderate calculus deposits noted. The dentist recommended scaling and "will submit or > suthorization to Medicaid for approval." Int arriew with the Qualified Mental Retardation P ofessional (QMRP) and facility's Licensed Practical Nurse (LPN) on February 8, 2008 at approximately 1:00 PM confirmed that Resident #2 had not been back to the dentist since December 4, 2006 almost a year later. The QMRP stated hat the facility was still waiting for approval for demal services (Scaling) and that she was following up with this issue. At the time of the survey, he facility failed to provide evidence that Resident #1 received timely dental services. The e was also no evidence of the facility's effort: to assist with the obtainment of the pre-author zation. 1394 3520.2(d) PROFESSION SERVICES: GENERAL 1394 **PROVISIONS** See response to 1042. Each GHMRP shall have available qualified 3/25/08 professional s aff to carry out and monitor necessary pro austonal interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by he interdisciplinary team. The professional surrices may include, but not be Health Regulation Administration

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	OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM 09G010	R/CLIA ABER:	A BUILDING B. WING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AME OF	ROVIDER OR SUPI LI	ER	000010	STEET	DODENO OTO A		02/	08/2008	
CARECO	01			6417 KA Washin	NSAS AVE, N GTON, DC 20	TATE, ZIP CODE E 001			
OX4) ID PREFIX TAG	LEACH DEFI: IF	NCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY TO IDENTIFYING INFORMA		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT IN CROSS-REFERENCED TO THE DEFICIENCY	on should he heapproprate	(X5) COMPLETI DAYS	
	REGULATOR FOR LSC IDENTIFYING INFORMATION)				1 394	DEFICIENCY)		
	preparing the inerportions that v. an interview with the revealed that [less When asked I owner to give to ust know, I've being the control of the currency 7, 2008; evened that I less revealed that	al de ser state de la ser	lid not measure the fived to Resident #2. If at approximately 6. If #2 is on a special of the sp	15 PM diet. Int of tated "(me." n d a 1800 let. vealed alorie pre was					

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AND FLAN	NT OF DEFICIENCIES OF CORRECTION		7) PROVIDER/SUPPLIE IDENTIFICATION NUI	MBER;	A. BUILD B. WING	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		
CARECO	PROVIDER,OR SUP D 01	*LER			ISAS AVE	r, state, zip code , NE 20001		08/2008
(X4) ID PREFIX TAG	! (EACH DEF	CIENCYM	MENT OF DEFICIENCIE UST BE PRECEDED BY IDENTIFYING INFORMA	Efn:	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULT: HE	(X5) COMPLETE DATE
! 395	Continued Fr	יזוי page	7		1 395			
1 395	3520,2(e) PR PROVISION:	or essi	ON SERVICES: G	ENERAL	1 395			
	professional accordance valued individual half necessary by professional alimited to, the trained, qualif	twif to ca fessiona ith the grillitation p the intervices r ervices r se service ed, and i ambia lav	ave available quality out and monitory out and monitors, in coals and objectives and objectives as determined disciplinary team. I may include, but not be provided by indicensed as required in the following services:	or s of every d to be The ot be				
	The GHMRP professional: (necessary professional: (accordance v i objectives of e determined to interdiscipline i included in the	ailed to e laff came lessional th clients vary indi be neces y team fo stample.	t as evidenced by: ensure that qualified out and monitor i interventions, in needs, the goals vidual habilitation essary by the or two of three resi (Resident #2 and	ed red sand plan, as				
	current physic is approximately a prescribed a ' Cadaptive equiparticensed Pira is Mental Retard 8, 2) revealed that the collar during the	to 322.1 an's orderside AM arvical (ment. In cal Nurse dion Pro- le client: d'une or ort Plan	Review of Clienters on February 7, revealed the clienter as part of historylew with the fall (LPN) and Qualifessional (QMRP) proximately 10:00 ashould wear the only. Review of Clienter amended	2008 at t was is cliity's fied on AM		1. The QMRP will ensure that the purp recommendations and length of time the should use the coivical collar is clearly s ISP. The QMRP will ensure that the statisting on how to implement and documes of the cervical collar, and that the number of the neck support.	client stated in his ffrective nor i the	<i>उक्तिर विश्व</i>

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STATEMENT OF DEFICIENCIE I AND PLAN OF CORRECTION		ORRECTION (X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION NG	(X3 DATES	COMPLETED	
			09 00 10				`		
AME OF F	ROMDER OR SUPI	LIER	<u></u>	STREET ADI	ADDRESS, CITY, STATE, ZIP CODE				
CARECO	ว.ก.1			6417 KAN	SAS AVE.	NE			
				WASHING	TON, DC	20001			
(X4) ID	SUMMA	IY STA	TEMENT OF DEFICIENCIE	s	ID.	PROVIDER'S PLAN OF C	ORRECTION	7	
TAG	REGULATOR.	OR L	MUST BE PRECEDED BY SCIDENTIFYING INFORMA	FULL TION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD 15 E APPROPRIATE	COMPLET DATE	
1396	Continued Fr	m paj	ge 8		1 395			·	
	"My assistive collar is to be facility. Further revealed that it inside the facility stated that it in this issue to the past ISP and refusals to we are Review of the dated Octobe purpose, recontinuous of the use of the appropriate in appropriate in protocol had in the protocol had in	Device worn interior	under the section eles", revealed that the at bedtime and when rview with the QMRF ent will not wear the ele will take it off. The redisciplinary Team (I staff to document in collar while in the facal Therapy assessment for direct care staff to entation for this preserview failed to reveale eveloped by the nurse sections and length of the direct care staff the entation for this preserview failed to reveale eveloped by the nurse sections and the care staff the entation for this preserview failed to reveale eveloped by the nurse sections.	ccervical in the collar collar collar collar collar collar collity ressing DT) this collity nent he f time for colled to collar					
	support the not implementation? 2. Cross referensure that C ke	ਲing : of th to 32; ent #3	ntation was available staff monitoring of the is neck support for C2.2. The facility failed is soft hand splints with the current physical states.	e Client #2. d to	,	2. The QMRP will ensure that the trained on the physician's orders splints, and ensure that staff implas written.	on the use of the	<i>ड/</i> ३४)	
	Each GHMRF : and assistanc : the resident ' :	iball p io res Individ	ON AND TRAINING provide habilitation, to sidents in accordance dual Habilitation Plantet as evidenced by:	= with	1 422 .'	The QMRP will ensure that staff are effectively trained in implem. IPPs, and that residential staff or encouraged to improve his self managed.	enting client#1's isure that he is	<i>ड र्टि</i>	
) 1 1 2	Based on obs a review, the farill as outlined in th	vator By fai e Indi of thre	n, interview and reco led to implement pro ividual Program Plan se clients included in	grame		,			

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	IT OF DEFICIENCIE OF CORRECTION	LIVIA LIZABIDAD	VTION NUMBER:	(X2) MUL A. BUILD B. WING		(X3) DATE (COMPL				
NAME OF F	ROVIDER OR SUP			ADDRESS OF	02/08/201 ADDRESS, CITY, STATE, ZIP CODE					
CARECO			6417 K	Cansas ave, Ington, DC	NE					
(X4) ID PREFIX YAG	! (EACH DEFI	JENCY MUST BE PRECI	ENGN BY BILL	ID PREFIX TAG	PROMDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD 3E TO THE APPROPRIATE	(X3) COMPLETS DATE			
l 422		· -		1 422						
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